# Child imMTrax Permission Form

**Please Print**

Childs Name:_____ Sex: M__ F__ Date of Birth:_____

I authorize my health care provider and a public health agency to collect and enter my child's immunization records into the Department of Public Health and Human Services' Immunization Information System (IIS). The IIS is a confidential, computer system that contains immunization records. I understand that information in the registry may be released to a public health agency as well as my health care providers to assist in my child's medical care and treatment. In addition, information may be released to child care facilities and schools in which my child is enrolled to comply with state immunization requirements. I understand that I can revoke this authorization and have my record removed at any time by contacting my local health department.

Client/Parent/
Guardian Signature:_____ Date:_____

Primary Health Care Provider: _____



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IZ Consent –101 (10/05/2012)